93-268

No.

Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1993

DIANE M. CUTTING and WARREN L. CUTTING,

Petitioners,

vs.

JEROME FOODS, INC.,

Respondent.

Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

What standard of review applies to an employer under the Employee Income Security Act of 1974 (ERISA), 88 Stat. Amended, 29 U.S.C. § 1001, *et seq.* which gives itself discretion to interpret an unfunded Plan and has a conflict of interest?

LIST OF PARTIES TO THE PROCEEDINGS

The parties to the proceedings below were the Petitioners, Diane M. Cutting and Warren L. Cutting and the Respondent, Jerome Foods, Inc. There are no parent companies or subsidiaries.

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No.

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Respondent.

Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

Petitioners, Diane M. Cutting and Warren L. Cutting request that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Seventh Circuit entered in this action on May 20, 1993, which affirmed a final judgment of the United States District Court for the Western District of Wisconsin.

OPINIONS BELOW

The opinion of the Court of Appeals is reported in 993 F.2d 1293. (App. A). The opinion of the District Court, __ F. Supp. __,

1991 UL 496134 at *6, 1991 U.S. Dist. *Lexis* 20573 at *16 is reproduced in Appendix B to this Petition.

STATEMENT OF JURISDICTION

The judgment of the Court of Appeals 993 F.2d 1293 (Pet. App. A) was entered on May 20, 1994. The jurisdiction of this court rests upon 28 U.S.C. § 1254(1).

STATUTES INVOLVED

29 U.S.C. § 1132(a)(1)(b):

> A civil action may be brought:
>
> (1) by a participant or beneficiary — (A) for the relief provided for in subsection (c) of this section, or (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
>
> (2) by the secretary [of Labor], or by a participant, beneficiary or fiduciary for appropriate relief under section 409;
>
> (3) by a participant, beneficiary, or fiduciary, (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;
>
> (4) by the Secretary [of Labor] or by a

participant, or beneficiary for appropriate relief in the case of a violation of 105(c);

(5) except as otherwise provided in subsection (b), by the Secretary [of Labor] (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title; or . . . .

29 U.S.C. § 1104(a)(1):

. . . subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and —

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the

> plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
>
> (D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter or subchapter III of this chapter [Titles I and IV of ERISA].

STATEMENT OF THE CASE

This case involves the application of a subrogation provision in the healthcare plan of Respondent, Jerome Foods, Inc. (Respondent). Petitioners Warren and Diane Cutting (Petitioners) are citizens of Wisconsin. Respondent is incorporated in Wisconsin and has its principal place of business in Wisconsin. Respondent is a non-union employer and had in effect a Plan under Section 29 U.S.C. § 1002(5) of the Employment Retirement Income and Security Act (ERISA) and provided a self-funded group health plan to its employees. Respondent was the Plan administrator, Plan sponsor and named fiduciary. The Plan was an employee welfare benefit plan within the meaning of ERISA. (R. 50). At all relevant times, Petitioner Warren Cutting was an employee of Respondent. (R. 50).

Respondent's health plans included the following which was entitled a "subrogation" provision:

> By accepting any Plan payments of benefits arising out of illness, injury or medical condition, an individual (covered employee or dependent) agrees that the Plan shall be subrogated to all claims, demands, actions and rights or recovery of the individual against any

> third party or any insurer, including Workers' Compensation, to the extent of any and all payments made or to be made hereunder by the Plan. The Plan shall be entitled to commence an action and try or settle any legal actions it deems necessary in the name of and with the full cooperation of the individual or to intervene in any such actions already commenced by an individual and will be reimbursed by the individual to the extent of any amounts paid or payable, past or future, from any third party by way of settlement or in satisfaction of judgment or agreement.
>
> The individual shall execute and deliver any and all instruments and papers requested by the Claim Administrator and shall do whatever is necessary to protect all of the Plan's rights. As a condition precedent to the payment of benefits hereunder, the individual shall, upon written request, execute a reimbursement agreement of the form to be provided by the Claim Administrator or its representative. The individual shall do nothing to prejudice the rights of the Plan to such reimbursement and subrogation and specifically agrees to notify and consult with the Claim Administrator before commencing any legal action concerning claims against any third party or its insurer relating to benefits paid hereunder. (R. 50).

The Plan granted the Plan administrator discretion to interpret the Plan. The provision states:

> Jerome Foods, Inc. shall be Plan Administrator and named fiduciary of the Plan. All decisions concerning the interpretation or application of this Plan shall be vested in the sole discretion of the Plan Administrator.

The health insurance plan was a self-administered employee benefit plan. The Respondent's vice-president, Mr. Glen Gleichert, was the plan administrator and named fiduciary. The Plan was financed from the general revenues of the Respondent. Gleichert had the authority to make all final decisions with regard to the Plan and authority to interpret the Plan. (R. 19). There was no trust account, or trust assets with regard to medical payments. The health care payments came directly from the general assets of the company. (R. 19).

On December 25, 1989 Diane Cutting was involved in a serious automobile accident. Diane suffered extensive injuries including extensive fractures to both legs. (R. 32). The undisputed value of Petitioners' injuries is $1,000,000. (R. 32).

Petitioners' uninsured motorist carrier, American Family Insurance Company (American Family) paid Petitioners $126,000 because of injuries sustained in the accident. (R. 32). In addition, Petitioners commenced an action against Ford Motor Company (Ford) which was settled in November, 1991. (R. 50). The lawsuit against Ford was based on a defective shoulder harness which enhanced the injuries to Diane Cutting. Any liability of Ford, however, was limited to injuries *above* the waist. (R. 33).

The medical bills at the time the District Court granted summary judgment, were slightly over $90,000. Most of the medical bills pertained to injuries below the waist, (R. 36), which were not compensable in any recovery from Ford (R. 33-B). The amount of settlement was submitted to the court, under seal (R. 26).

The total amounts received from American Family and Ford was less than $650,000. The money received was far short of the $1,000,000 value of the injuries sustained by the Cuttings. (R. 32). *It is not disputed that the funds received by Diane were insufficient* to fully compensate for her injuries.

The medical bills from this accident were about $90,000. These were paid by Petitioner from funds collected from American Family (U.M. coverage) and Ford (enhanced injury claim). Respondent did not pay any of the medical bills.

A. The Proceedings Below.

Petitioners refused to sign a reimbursement agreement, since Petitioners were not fully paid for the injuries sustained. Petitioners then commenced this action for declaratory judgment in Barron County Circuit Court, State of Wisconsin. The action was removed by Respondent to the United States District Court for the Western District of Wisconsin. The federal District Court has jurisdiction over this matter pursuant to 29 U.S.C. § 1132(e)(2) and (f) of ERISA as amended and federal question jurisdiction pursuant to 28 U.S.C. § 1331. A motion for summary judgment was filed by Respondent together with affidavits and proposed findings of fact and conclusions of law. Petitioners submitted affidavits and briefs in opposition, and also asked the court to determine, as a matter of law, that Respondent was required to reimburse the Petitioners for all funds Petitioners had paid for medical services connected with the underlying accident.

In a memorandum decision entered on January 31, 1992, the District Court granted Respondent's motion for summary judgment holding Petitioners were required to sign a reimbursement agreement. The effect of this ruling was that Petitioners were responsible to pay their own medical expenses as long as there were *any* funds received from either American Family or Ford to cover such bills. The District Court held the facts of this

case (unfunded plan with employer administering the plan) did not create a conflict.

The Court of Appeals affirmed the federal District Court. The Seventh Circuit Court of Appeals has jurisdiction pursuant to 28 U.S.C. § 1291. In a decision filed on May 20, 1993, the Court of Appeals found the standard of judicial review was "critical" and Respondent's interpretation of the subrogation clause was "not unreasonable." The Court of Appeals affirmed the District Court.

REASONS FOR GRANTING THE WRIT

Certiorari should be granted to resolve the conflict between circuits concerning the standard that applies to an ERISA employer which gives itself discretion to interpret the provisions of an unfunded plan.

In this case, the Seventh Circuit standard of review was based on whether Respondent's interpretation of the subrogation provision was "reasonable." The Seventh Circuit is in conflict with the standard of review announced by the Eleventh Circuit which will determine if the decision of the employer was wrong. The Seventh Circuit is also in conflict with the Tenth Circuit which will not uphold an erroneous application of law. Finally, the Seventh Circuit is also in conflict with legal scholars who opine that when an employer gives itself discretion to interpret an unfunded plan, review should be *de novo*. These conflicts among the circuits have resulted in a lack of uniformity and workers have less protection now than prior to the passage of ERISA.

I.

PRIOR UNITED STATES SUPREME COURT DECISIONS HAVE NOT SET A STANDARD OF REVIEW WHEN A PLAN ADMINISTRATOR HAS A CONFLICT.

The Supreme Court set out the standard for reviewing a denial of benefits challenged under § 502(a)(1)(B) of ERISA in *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989). *Bruch* rejected the wholesale importation of the arbitrary and capricious standard developed in pension cases arising under the Labor Management Relations Act, 29 U.S.C.A. § 186(c) ("LMRA") into ERISA. 489 U.S. at 109.

The standard of review of an action challenging a benefit eligibility determination is *de novo,* unless the benefit plan gives the administrator discretionary authority to construe the terms of the plan. 489 U.S. at 115. If a claimant challenges a fiduciary's discretionary decision, a more deferential standard is appropriate. *See id.*

Bruch held that, even under the deferential "abuse of discretion" standard of review, evidence of administrative bias remains relevant. "[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion." 489 U.S. at 115 (quoting *Restatement (Second) of Trusts* § 187, Comment d (1959)). There was no discussion in *Bruch* as to how this "factor" would be applied or whether the "abuse of discretion" standard is still the standard in the face of a conflict.

The Court in *Bruch* did not set out the standard of review that applies when an employer gives itself discretion to construe an unfunded plan and has a conflict of interest. This is such a case.

II.

THE SEVENTH CIRCUIT "REASONABLE" STANDARD IS IN CONFLICT WITH THE SUPREME COURT AND OTHER CIRCUITS.

The Seventh Circuit, in this case, held that when a plan vests discretion in the employer over an unfunded plan, courts have power to overrule the employer *only* when the administrator "acted unreasonably," citing *Bruch.* (Pet. App. A-5a). The court also stated that the question was "sufficiently close that a differential standard of review dictates affirmance of the plan's decision . . ." (Pet. App. A-6a).

The Seventh Circuit derived the "reasonable" standard from what it viewed to be "such familiar and possibly synonymous terms as 'abuse of discretion' and 'arbitrary and capricious' (between which the Court found it unnecessary to choose) for which clear error may be a further synonym." (Pet. App. A-4a). Thus, the Court of Appeals stretched the standard of "reasonable" to include "abuse of discretion" and "arbitrary and capricious" as well as "clear error."

The Seventh Circuit applied the "reasonable" standard when there was a conflict of interest of an unfunded employer-administered plan. The Court, however, acknowledged the grant of discretion to Respondent did not strip beneficiaries of all legal remedies, "especially given the *conflict of interest* inherent in an unfunded employer administered plan." (Pet. App. A-4a). (Emphasis added). The court applied the "reasonable" standard without weighing, in any way, the conflict of interest of Respondent. This is contrary to dicta in *Bruch.* This standard ("reasonable") is also in conflict with other Circuits.

III.

THE ELEVENTH CIRCUIT RULE: WAS THE DECISION WRONG?

The Eleventh Circuit has articulated a standard that applies when the administrator has a conflict and discretion to construe the plan:

> [W]e hold that when a plan beneficiary demonstrates a substantial conflict of interest on the part of the fiduciary responsible for benefits determinations, the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest. That is, a wrong but apparently reasonable interpretation is arbitrary and capricious if it advances the conflicting interest of the fiduciary at the expense of the affected beneficiary or beneficiaries unless the fiduciary justifies the interpretation on the ground of its benefit to the class of all participants and beneficiaries.

Brown v. Blue Cross and Blue Shield of Alabama, Inc., 898 F.2d 1556, 1566-67 (11th Cir. 1990).

The *Brown* standard takes the conflict of interest into account. A wrong but apparently reasonable interpretation is arbitrary and capricious if it advances a conflicting interest of the fiduciary at the expense of the beneficiaries *unless* the fiduciary justifies the interpretation on the ground of its benefit to the class of all participants or beneficiaries. *Brown*, 898 F.2d at 1561-62.

Brown requires that a court must first determine if the conflict

exists. If there is a conflict, it must determine the correct interpretation of the Plan at issue. In determining whether the interpretation is correct, courts have considered whether the interpretation is consistent with the goals of the Plan; whether the interpretation renders any language in the Plan meaningless or is internally inconsistent; and whether the interpretation conflicts with a substantive or procedural requirement of the ERISA statute. *Finley v. Special Agents Mut. Ben. Ass'n., Inc.*, 937 F.2d 617, 621 (8th Cir. 1992).

The Seventh Circuit does not consider conflicts of interest. This is in conflict with *Brown*. It is also in conflict with the principles of trust law. *See* discussion Section V. *infra*.

IV.

OTHER JURISDICTIONS HAVE APPLIED THE *DE NOVO* STANDARD WHEN THERE IS AN ISSUE OF LAW.

The Tenth Circuit has stated that when a Plan administrator is given authority to construe "doubtful" provisions of the Plan, such interpretation will be upheld unless it involves an erroneous application of law.

> Woolsey first challenges the trial courts grant of summary judgment regarding the Administrators' alleged violation of 29 U.S.C. § 1132 in denying Woolsey's request for payment in Marion stock. The decisions of the administrators of a pension plan will be upheld unless they are arbitrary and capricious, not supported by substantial evidence or erroneous on a question of law. *Pratt v. Petroleum Prod. Management, Inc. Employee Sav .Plan & Trust*, 920 F.2d 651, 657 (10th Cir. 1990); *Torix*

> *v. Ball Corp.*, 862 F.2d 1428, 1429 (10th Cir. 1988); *Sage v. Automation, Inc. Pension Plan & Trust*, 845 F.2d 885, 895 (10th Cir. 1988). For claims brought under § 1132, this deferential standard of review [is] appropriate when a trustee exercised discretionary powers . . . [and] "a court of equity will not interfere to control [trustees] in the exercise of a discretion vested in them by the instrument under which they act." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111, 109 S. Ct. 948, 954, 103 L. Ed. 2d 80 (1989) (emphasis omitted).

Woolsey v. Marion Laboratories, Inc., 934 F.2d 1452, 1457 (10th Cir. 1991).

> Thus, if the Plan gives the retirement committee "discretion . . . to construe 'doubtful' provisions of the plan itself," *De Nobel v. Vitro Corp.*, 885 F.2d 1180, 1186 (4th Cir. 1989), the committee's decision must be upheld unless it was "arbitrary and capricious, not supported by substantial evidence or erroneous on a question of law." *Woolsey v. Marion Lab., Inc.*, 934 F.2d 1452, 1457 (10th Cir. 1991); see also *Nauble v. O'Connel*, 833 F.2d 1391, 1393-94 (10th Cir. 1987) (trustee's decision "neither arbitrary nor capricious if it is based on substantial evidence and is not the result of a mistake of law").

Millensifer v. Retirement Plan, 968 F.2d 1005, 1009-1010 (10th Cir. 1992).

The legal question in the present case is this: Does subrogation

law allow Respondent to collect proceeds from third parties before the injured party beneficiary is made whole? Respondent said yes. The law of equitable subrogation says no.

V.

DE NOVO REVIEW IS REQUIRED WHEN EMPLOYER HAS A CONFLICT.

ERISA was enacted in 1974. The objective of ERISA is protection of workers with a comprehensive statutory scheme. The Act enumerates fiduciary responsibilities with respect to plan disclosure and administration and provides both civil and criminal remedies to enforce these provisions. Administration of ERISA is shared by the Secretary of Labor and the Internal Revenue Service. *See generally,* Martin Wald and David E. Kenty, *ERISA: A Comprehensive Guide,* § 1.1-1.4 (Wiley Law Pub. 1991); and Ronald J. Cooke, *ERISA Practice & Procedure* (McGraw-Hill, Inc. 1992).

The duties of a plan fiduciary are enumerated in Title 29 U.S.C. § 1104. Subsection (a) of § 1104 requires that plan fiduciaries discharge their duties "solely in the interests of the participants and beneficiaries," and that they do so in a "prudent" manner. The section defines a "prudent man standard" as follows:

> [T]he care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiarly with such matters would use in the conduct of an enterprise of like character and with like aims.

Any time an employer serves as plan administrator and the benefits are unfunded, there is such a conflict that *de novo* review is

required. The wholesale importation of the arbitrary and capricious standard into ERISA was criticized in *Bruch* because it left employees worse off than before ERISA. 109 S. Ct. at 954. This same rationale applies to the review of the decisions of plan administrators who have a conflict.

> The spectrum of potential plan administrators runs from the employer serving as the plan administrator to the equally balanced LMRA plan administrator. Congress did not intend, nor is it wise, to treat all types of plan administrators equally. Clearly the employer serving as a plan administrator functions as an interested plan administrator to which the de novo review rule should apply. The LMRA plan administrator, however, is disinterested, and therefore, the arbitrary and capricious rule should apply. Between these two extremes, the common arrangements for a plan administrator involve a committee of high management officials, a committee of employees and service providers. Because of actual conflicts of interest that high management employees have as plan administrators between their duty of loyalty to the corporation as managers and their duty of loyalty to the plan as fiduciaries, the court should conclusively presume them interested plan administrators to which de novo review applies.

George Lee Fling, Jr., *ERISA: The Arbitrary and Capricious Rule Under Siege,* 39 Catholic University Law Review 133, 174-175.

The *de novo* review standard should apply when there is a conflict of interest. This is consistent with trust law upon which the

Bruch decision is based as well as the overall objectives of ERISA.

> The remaining question concerns the applicable rule for court review of a plan administrator's discretionary power to interpret the plan. As shown above, trust law generally applies to ERISA plans. Trust law provides that the court, not the trustee, interprets the trust's terms, even when the trustee possesses interpretive discretion. Usually, the rules of trust construction, as with deeds and wills, dictate that the courts construe the trusts in favor of the conveyancer/settlor's intent. This is appropriate when the trustee has no interpretive discretion. However, when the trustee does possess the discretion, trust law requests a court to review the decision under the "abuse of discretion" standard used for other discretionary actions. *This means that a court will use de novo review for the interested employer plan administrator, tending to construe the plan's terms against the employer, as courts did under the pre-ERISA state decisions favorably commented upon by the Supreme Court.* A court using the prudent man rule would reach a similar result. Welfare plans often resemble insurance contracts in which the court construes the terms against the draftsman. Hence, a prudent plan administrator should similarly interpret the welfare plan as if it were an insurance contract.

Id. pp. 178-179 (emphasis added).

VI.

RESPONDENT HAD A CONFLICT OF INTEREST.

Where a benefit trust is not funded and the employer incurs a direct, immediate expense as a result of benefits determinations favorable to plan participants, there is a conflict of interest. In such a setting there exists a "presumptive bias" of administrators who serve dual roles of company officer and plan fiduciary. *Lowry v. Bankers Life & Casualty Retirement Plan,* 871 F.2d 522 (5th Cir. 1989); *De Nobel v. Vitro Corp.*, 85 F.2d 1191 (4th Cir. 1989). Such was the unfunded plan at issue in *Bruch,* where "every dollar provided in benefits is a dollar spent by . . . Firestone, the employer; and every dollar saved by the Administrator on behalf of his employer is a dollar in Firestone's pocket." *Firestone Tire and Rubber Co.*, 828 F.2d 134, 144 (3d Cir. 1987).

The Seventh Circuit, in this case, acknowledged that "every penny paid out in plan benefits comes out of the company coffers; and even with funded or insured welfare plans, the employer has a financial stake in limiting the payment of benefits." (Pet. App. A-3a). The court also acknowledged the "conflict of interest inherent in an unfunded employee administered plan." (Pet. App. A-4a).

There can be no clearer conflict of interest than an employer (Respondent) which appoints its vice-president as the sole arbiter of an unfunded plan.

VII.

RESPONDENT APPLIED THE WRONG INTERPRETATION AND MADE A MISTAKE OF LAW.

Brown held that a court must first decide if a plan administrator made a correct interpretation of the plan. In this case,

Respondent's use of its subrogation provision was contrary to federal common law rules of subrogation and is wrong.

Federal common law under federal statutes is applied when there is a need to protect federal interests or if Congress has given courts the authority to develop substantive law. *Texas Industries, Inc. v. Radcliff Materials, Inc.*, 451 U.S. 630, 640 (1981). *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) held courts are to develop federal common law of rights and obligations under ERISA-regulated plans. *See also Cummings by Techmaier v. Briggs & Straton*, 797 F.2d 383 (7th Cir. 1986). Federal common law rules apply to ERISA plans. *Bruch, supra.* Congress did not suspend or supplant the law of subrogation when it passed ERISA.

A subrogation provision brings with it the established federal common law which applies to subrogation. The federal common law of subrogation is well established.

> A surety who has undertaken to pay the creditors of the principal, though not beyond a stated limit, may not share in the assets of the principal by reason of such payment until the debts thus partially protected have been satisfied in full. This is the rule where the right to a dividend has its basis in the principle of equitable subrogation.
>
> "A surety liable only for part of the debt does not become subrogated to collateral or to remedies available to the creditor unless he pays the whole debt or it is otherwise satisfied." *United States v. National Surety Co.*, 254 U.S. 73, 76, 65 L. ed. 143, 144, 41 S. Ct. 29.

American Surety Co. v. Westinghouse Electric Manufacturing Co., 296 U.S. 133, 137 (1935).

In *United States v. National Surety Co.*, 254 U.S. 73, 76 (1920), Justice Brandeis also stated:

> A surety liable only for part of the debt does not become subrogated to collateral or to remedies available to the creditor unless he pays the whole debt or it is otherwise satisfied.

If a subrogation provision does not provide for *pro tanto* subrogation, no subrogation is allowed until the debt is fully satisfied. *Maryland Casualty Co. v. Southern Pac. Co.*, 119 F.2d 672 (9th Cir. 1941). *Compania Anonima Venezolana De Navegacion v. A. J. Perez Export Co.*, 303 F.2d 692 (5th Cir. 1962), *cert. denied,* 371 U.S. 942, outlined in detail the federal common law rules of subrogation and its foundation in equity:

> "Consequently, relief by way of subrogation will not be granted where it would work injustice, or where innocent persons would suffer, or where the result would be inimical to a sound public policy" § 11 at 690. As "subrogation is administered upon equitable principles, it is only where an applicant has an equity to invoke that the courts will interfere. Moreover, the equity of the party seeking subrogation must be strong and his rights clear, and his equity must be superior to that of other claimants." § 12 at 690-91. And it "will not be enforced to the prejudice of other rights of equal or higher rank, or to displace an intervening right or title, or to overthrow the equity of another person." § 13 at 691-92. Subrogation "is not an absolute right which a party paying the debt of another may enforce at will, but rather, a matter of grace to be granted

> or withheld as the equities of the case may demand." § 16 at 693. The whole aim of subrogation "is the doing of equity and injustice and the relief will not be decreed where it will work an injustice, and so it cannot be invoked to the injury of innocent third person."

303 F.2d 629, 693, 697.

> In general, the equity of the party seeking subrogation must be clear and substantial, and superior to that of other claimants. Finally, subrogation cannot be invoked where it would work an injustice, violate sound public policy, or result in harm to innocent third persons.

Universal Title Ins. Co. v. United States, 942 F.2d 1311, 1315 (8th Cir. 1991).

Subrogation is based on equity. This means that a surety cannot be paid (obtain subrogation) until the debt has been paid in full. In this case, Respondent cannot take part in the recovery of money from third parties (U.M. carrier and tortfeasor) until Petitioners have obtained full recovery. Respondent was wrong when it failed to properly apply the subrogation provision it wrote into its Plan.

The Seventh Circuit did not determine if Respondent's interpretation was "wrong." *Brown,* 898 F.2d at 1566-67. The court did, however, hold that the standard of review was "critical" and Respondent was not "unreasonable" in ignoring the law of equitable subrogation.

But at this point in the forensic badminton

> game the standard of judicial review becomes critical and decides the case in favor of Jerome Foods. For we cannot say that the company was unreasonable in interpreting this plan as disclaiming the make-whole principle.

(Pet. App. A-11a).

The Respondent's subrogation clause does not "clearly and explicitly" suspend the rules of equitable subrogation. Respondent's subrogation provision does not allow Respondent to claim funds from third parties before Petitioners get anything.

> However, subrogation remains an offspring of equity. Thus, even when the right to subrogation arises by virtue of an agreement, the terms of the subrogation will nonetheless be governed by equitable principles, unless the agreement clearly and explicitly provides to the contrary . . . .
>
> * * *
>
> Given its origins in equity and its restitutionary purpose of preventing unjust enrichment, the general rule is that subrogation, whether arising from equity or contract, will be denied prior to full recovery. That is, absent express contract terms to the contrary, subrogation will not be allowed where the insured's total recovery is less than the insured's actual loss. See 16 Couch on Insurance 2d § 61:61 (1966); see also 3 Appleman Insurance Law and Practice § 1675 (1967); Patterson, Essentials of Insurance Law § 33 (1957).

Similarly in *Lyon v. Hartford Accident & Indemnity Co., supra,* 480 P.21d at 744-45, the court stated:

> Since subrogation is an offspring of equity, equitable principles apply, even when the subrogation is based on contract, except as modified by specific provisions in the contract. In the absence of express terms to the contrary, the insured is entitled to be made whole before the insurer may recover any portion of the recovery from the tort-feasor. If the one responsible paid the full extent of the loss, the insured should not claim both sums, and the insurer may then asset its claim to subrogation.

International Underwriters v. Liao, 548 So. 2d 163, 165 (Ala. 1989).

The Respondent's subrogation provision did not expressly state that Respondent can recover funds before beneficiaries have been "made whole."

The Seventh Circuit acknowledged that rejection of the "make whole" doctrine would curtail benefits for employees and courts have held subrogation provisions cannot have this effect. (Pet. App. A-9a-10a). The Seventh Circuit, however, also opined that (1) subrogation reduces the cost of insurance; and (2) the "make whole" rule is administratively complex. (Pet. App. A-10a). There is nothing in this record that in any way establishes that subrogation reduces costs (1) to the insurance industry; (2) for ERISA plans; or (3) for Respondent. *See, e.g.,* Meyers, *Subrogation Rights and Recoveries Arising Out of First Party*

Contracts, 9 Forum 83, 84-85 noting that subrogation net recoveries amounted to 0.68 per cent of paid fire losses and 0.80 percent of homeowner claims. Respondent has not provided any *evidence* that rejection of the made whole rule is consistent with ERISA, or rejection of the made whole rule benefits all participants or beneficiaries. *Brown,* 898 F.2d at 1561-62.

Respondent was wrong when it applied its subrogation clause to give Respondent the right to collect the first $90,000 recovered from any third parties. Respondent was wrong in its application of subrogation law. ERISA (and Respondent's Plan) did not suspend or do away with the equitable principles upon which subrogation is based.

Respondent invoked the rules of subrogation in its health insurance plan. Once Respondent decided to use subrogation, it could not check at the door those aspects of subrogation law it did not like. No ERISA plan should be able to defeat the common law principal that a beneficiary must be "made whole." At the very least, subrogation law requires that the make whole doctrine can only be abandoned by clear and explicit language. Respondent did not do this. Therefore, as a matter of law, Respondent was wrong when it used its subrogation provision to claim it was entitled to the first $90,000 collected from third parties.

CONCLUSION

There is a conflict among the Circuits about which standard to apply when plan administrators have discretion and a conflict. The rule in the Seventh Circuit is different from the Eleventh Circuit. The rule in the Tenth Circuit is different then the rule in both the Seventh and Eleventh Circuits. All of the Circuits which have addressed the issue have announced rules at variance with trust law and the objectives of ERISA. Catholic University Law Review, *supra.*

The result? Employers are using ERISA as a sword to limit benefits. ERISA is not available as a shield to protect employee benefits. Employers with conflicts sharpen their draftsmanship to render unto themselves the right to interpret plans and limit recoveries. In the end, Petitioners are left with no health insurance for Diane Cutting's injuries because of the self-serving interpretation Respondent has given to its "equitable" subrogation provision.

Petitioners therefore respectfully ask that this petition be granted.

Respectfully submitted,

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APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT DATED MAY 20, 1993

UNITED STATES COURT OF APPEALS

SEVENTH CIRCUIT

No. 92-1405

DIANE M. CUTTING AND WARREN L. CUTTING

Plaintiffs-Appellants,

v.

JEROME FOODS, INCORPORATED,

Defendant-Appellee,

Argued Nov. 6, 1992 — Decided May 20, 1993.

Arnold P. Anderson (argued), Mohr, Anderson & McClurg, Hartford, WI, for plaintiffs-appellants.

Howard R. Flaxman (argued), Nina A. Riasanovsky, Blank, Rome, Comisky & McCauley, Philadelphia, P.A., Bradley C. Lundeen, Gilbert, Mudge, Porter & Lundeen, Hudson, WI, for defendant-appellee.

Before POSNER and FLAUM, Circuit Judges, and WILLIAMS, District Judge.[1]

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1. Hon. Ann Claire Williams of the Northern District of Illinois, sitting by designation.

Appendix A

POSNER, Circuit Judge.

Diane Cutting was seriously injured in an automobile accident. She has incurred $90,000 in medical expenses alone, and expects to incur additional medical expenses in the future. An uninsured-motorist policy paid her $126,000 and she recovered another half million dollars on a products-liability claim, but as she reckons her total damages from the accident at $1 million there is a considerable shortfall. Her husband's employer, Jerome Foods, Inc., has an unfunded, company-administered employee benefits plan that covers spouses. The Cuttings submitted Mrs. Cutting's medical expenses to the plan for payment. The plan was willing to pay — provided the Cuttings agreed to reimburse it for any amounts that they had received from other sources. The basis of this demand was the subrogation clause of the benefits plan, which provides that by accepting any payment of plan benefits the covered employee or dependent "agrees that the Plan shall be subrogated to all claims, demands, actions and rights of recovery of the individual against any third party or any insurer, including Workers' Compensation, to the extent of any and all payments made or to be made hereunder by the Plan." The Cuttings refused to reimburse the plan, contending that a right of subrogation does not arise unless the covered individual has been made whole, in which case the payment of benefits under the plan would confer a windfall. If it is assumed that Diane Cutting really did sustain a loss of $1 million of which more than $900,000 is for items of loss or expense other than medical expenses, then since she has recovered less than $650,000 the effect of subrogation would be to reduce her recovery of nonmedical expenses by the exact amount of her plan payments, so that she would derive no benefit in fact from the plan. Although there would be a sense in which her medical expenses had been fully paid (by the product manufacturer and the uninsured-motorist insurer), it would be a misleading sense. The

"payment" would be out of money that would otherwise have been hers to apply to other items of loss caused by the accident that gave rise to the medical expenses.

The company rejected the Cuttings' interpretation of the subrogation clause, precipitating this declaratory judgment action by the Cuttings. Having removed the suit to federal court because the plan is governed by the Employee Retirement Income and Security Act (ERISA), 29 U.S.C. §§ 1001 *et. seq.*, Jerome Foods moved successfully for summary judgment. 820 F.Supp. 1146.

The plan provides that "all decisions concerning the interpretation or application of this Plan shall be vested in the sole discretion of the Plan Administrator," that is, Jerome Foods. Read literally, this terminology would extinguish all judicial review of refusals by Jerome Foods to pay benefits. The company concedes, however, that it should not be read literally — that it is not a license to make arbitrary or capricious decisions on applications for benefits. *Cf. Lister v. Stark,* 942 F.2d 1183, 1188 (7th Cir. 1991). Were it otherwise, the coverage provided by the plan would be, not illusory exactly but noncontractual, because the company could turn down an application for benefits on whim. It might sometimes be tempted to do so. The plan is unfunded, with the result that every penny paid out in plan benefits comes out of the company's coffers; and even with funded or insured welfare plans, the employer has a financial stake in limiting the payment of benefits.

Of course, a company that is capricious in its bestowal of benefits may have to pay higher wages to compensate its workers for the anticipated reduction in the certainty and value of their benefits, or it may incur the potentially costly ill will of the workers. Some workers might prefer to rely on their employer's long-term self-interest in playing fair with benefits than to insist on

a costly regime of legal rights for which they pay indirectly in lower wages or more limited benefits, just as many workers appear to prefer jobs in which they are employees at will to tenured positions as civil servants. We are not certain that there is any legal impediment to a plan's forbidding judicial review of the plan administrator's decisions. ERISA provides that "a civil action may be brought by a participant or beneficiary . . . to recover benefits due," 29 U.S.C. § 1132(a)(1)(B), but if the plan entrusts the determination of what is due to the unreviewable discretion of the plan administrator, it can be argued that no benefits *will* be due unless the administrator awards them. And although the Supreme Court held in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S.Ct. 948, 956, 103 L.Ed.2d 80 (1989), that the default standard of judicial review of a plan administrator's decision is *de novo* review, it also held that if the plan gives the administrator discretion to construe its provisions the court will defer. *Id.*, at 111, 115, 109 S.Ct. at 954, 956; *Lister v. Stark, supra*, 942 F.2d at 1187-88. Not defer completely, however — defer in the sense conveyed by such familiar and possibly synonymous terms as "abuse of discretion" and "arbitrary and capricious" (between which the Court found it unnecessary to choose), for which clear error may be a further synonym. *Id.* at 1188; *Haugh v. Jones & Laughlin Steel Corp.*, 949 F.2d 914, 916-17 (7th Cir.1991). It is one thing to interpret a provision that vests discretion in a plan administrator as commanding judicial deference within reason, another thing to interpret it as commanding complete deference. The indications that the latter was intended would have to be pretty conclusive to persuade us, and we agree with the parties that the reference to "sole discretion" is not (quite) conclusive evidence of such an intention and therefore should not be interpreted to strip the plan's beneficiaries of all legal remedies, especially given the conflict of interest inherent in an unfunded employer-administered plan. (Compare the hostility of trust law to efforts by a trustee to place

himself beyond liability for profiting from a breach of trust. *Restatement (Second) of Trusts* § 222(2) (1959).) Otherwise the employees would have no contractual protection.

It is true, as we have pointed out, that employees often bargain away contractual protection. That is of the essence of the regime of employment at will, which is still the dominant regime for employment in this country. But this is only to say that employees normally will not pay for job insurance beyond what arrangement for unemployment compensation and severance pay provide them. They *will* pay for medical insurance and they usually want more assurance of insurance that an unenforceable promise from their employer would give them. Although an employer's concern for employee relations and good will will inhibit him from indulging in wholly irrational self-serving interpretations, it is not a complete guarantee. A rational employer will trade off the cost of such an interpretation against the gain in reduced expense, which might be critical, especially for employers in a financially parlous state. A good business reputation is not a very valuable asset to a firm that has little confidence of being able to remain in business long enough to profit from that reputation. Long-run self-interest is a weak constraint on firms that have poor long-run prospects.

So the Cuttings are entitled to judicial review of the company's ruling. But they are wrong to argue that the standard of judicial review is *de novo* — that we should give no weight to the company's interpretation. That as we said is the default standard. If the plan itself vests discretion in the administrator — if as here it gives the administrator a long leash — the courts pull back and defer broadly although not totally to the administration's determination, upending it only if persuaded that the administrator acted unreasonably. *Firestone Tire & Rubber Co. v. Bruch, supra,* 489 U.S. at 115, 109 S.Ct. at 956.

The interpretive question is sufficiently close in this case that a deferential standard of review dictates affirmance of the plan's decision, and hence of the district court's decision. We may put to one side Jerome Foods' argument that all that the Cuttings are contending is that we should apply Wisconsin subrogation law to this case. Wisconsin is indeed a state that recognizes the "make whole" qualification to a subrogee's rights; but the Cuttings concede as they must that ERISA preempts state law dealing with the interpretation of an ERISA plan, unless, as is not the case here, the plan involves the purchase of an insurance policy as the method of providing plan benefits. See *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990), holding a state subrogation rule preempted; *Provident Life & Accident Ins. Co. v. Linthicum*, 930 F.2d 14 (8th Cir.1991) (per curiam) (ditto). The Cuttings do not ask us to apply state law. They ask us to adopt a federal common law rule to the effect that rights of subrogation are enforceable only after the plan beneficiary has been made whole for the loss giving rise to the claim for benefits. That the federal rule might coincide with the law of Wisconsin is of no moment — especially since the Cuttings argue that the rule for which they contend the universal rule applied in subrogation cases, in which event it is *necessarily* identical to the Wisconsin rule.

There is no doubt about the authority of the federal courts to create common law for use in ERISA cases. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56, 107 S.Ct. 1549, 1557, 95 L.Ed.2d 39 (1987); *Fox Valley & Vicinity Construction Workers Pension Fund v. Brown*, 897 F.2d 275, 281 (7th Cir. 1990) (en banc). We suppose that even Jerome Foods would concede that these courts have to adopt *some* interpretive principles, even if only implicit ones, in order to construe ERISA plans, since ERISA sets forth no principles of interpretation of its own. And those principles that the judges devise or adopt to guide their interpretations are therefore

common law, that is, judge made, principles.

As it happens, the so-called universal rule of subrogation for which the Cuttings contend is a rule of interpretation. No one doubts that the beneficiary of an insurance policy or (as here) an employee welfare or benefits plan can if he wants sign away his make-whole right, *Garrity v. Rural Mutual Ins. Co.*, 77 Wis.2d 537, 253 N.W.2d 512, 515 (1977); *Lyon v. Hartford Accident & Indemnity Co.*, 25 Utah 2d 311, 480 P.2d 739, 744 (1971), overruled on other grounds in *Beck v. Farmers Ins. Exchange*, 701 P.2d 795, 798 (Utah 1985); *Wimberly v. American Casualty Co.*, 584 S.W.2d 200, 204 (Tenn.1979). The right exists only when the parties are silent. It is a gap filler. We need not consider the judges' power to impose substantive or remedial, as distinct from merely interpretive, common law principles, on ERISA plans; need not consider, that is, the extent to which common law reasoning can be used to enlarge (or contract) the rights of an ERISA beneficiary or participant. The scope of that power is uncertain, *Martin v. Consultants & Administrators, Inc.*, 966 F.2d 1078 (7th Cir. 1992); *Greany v. Western Farm Bureau Life Ins. Co.*, 978 F.2d 812, 821-22 (9th Cir.1992), because of the possibility of conflict between a specific substantive or remedial principle, such as equitable estoppel, and the substantive or remedial principles set forth in ERISA itself, such as the requirement (with which equitable estoppel might be thought inconsistent) that all plan benefits be in writing. Cf. *Decatur Memorial Hospital v. Connecticut General Life Ins. Co.*, 990 F.2d 925, 926-927 (7th Cir.1993). We are dealing only with an interpretive principle.

It is difficult to say whether the "make whole" interpretive principle is predominant, let alone universal. The treatises do not agree on the point. Compare 16 Mark S. Rhodes, *Couch on Insurance Law* § 61:64 at pp. 145-47 (2d rev. ed. 1983), and Allan

D. Windt, *Insurance Claims and Disputes: Representation of Insurance Companies and Insureds* § 10.06 at pp. 533-39 (2d ed. 1988), with Robert E. Keeton & Alan I. Widiss, *Insurance Law: A Guide to Fundamental Principles, Legal Doctrines, and Commercial Practices* § 3.10(b) at pp. 233-40 (1988). Although all but one modern case that we have found give lip service to it as the default rule (the exception is *In re Estate of Scott*, 208 Ill.App.3d 846, 153 Ill.Dec. 647, 649, 567 N.E.2d 605, 607 (1991)), many allow it to be overridden by a boilerplate subrogation clause. (With the *Garrity, Lyon,* and *Wimberly* cases, cited earlier, compare *Foremost Life Ins. Co. v. Waters*, 415 Mich. 303, 329 N.W.2d 688 (1982) (per curiam), and *Peterson v. Ohio Farmers Ins. Co.*, 175 Ohio St. 34, 191 N.E.2d 157, 159 (1963).) The rule hardly exists, as a practical matter, in the states that allow this.

It is difficult to say which is the better rule. In the usual case the insured incurs a medical expense for which he is promptly reimbursed by the insurance company (or equivalent), which then exercises its right of subrogation and goes off on what sometimes proves to be a wild goose chase after a possible tortfeasor to whom the expense can be shifted. The insured is out of the picture — well, not entirely, because he is entitled to any excess recovery by the insurance company. Subject to this qualification, of which more later, the risk of an uncertain recovery is shifted from the individual to a specialist in bearing risk and enforcing claims — the insurance company. The price of the insurance is thereby reduced (or, equivalently, the insured can buy more insurance for the same price) because the insurance company acquires a contingent claim by virtue of the subrogation clause. Without subrogation, a part of the risk is shifted back to the insured. He pays more for the insurance because he retains, rather than (in effect) sells, a right to obtain through litigation a recovery that may actually exceed the actual loss that (after receiving the insurance proceeds) he

suffered. This is because, by virtue of the collateral benefits rule, a tort plaintiff need not deduct from the judgment he receives in his tort suit compensation for the same loss which he may have obtained from another source, such as an insurance policy.

A legal right, for example a tort victim's right to sue his tortfeasor for damages, is like a lottery ticket. Its payoff is highly uncertain. Subrogation, consistent with the objective of insurance, transfers the lottery ticket from the individual policyholder to the collectivity of policyholders. The risk is spread, and by being spread eliminated or at least greatly reduced. Subrogation also eliminates the incentive to careless behavior created by the collateral benefits rule, which by enabling the insured victim a tort to recover for the same loss from both the insurance company and the tortfeasor may (depending on the adequacy of tort damages) make the tort victim better off than he would have been had there been no accident.

So it is not surprising that subrogation clauses are a common feature of insurance policies. But the "make whole" issue is not about whether insurance subrogation is in general a good thing, as it doubtless is. A "make whole" rule does not enable the insured to gamble on double recovery, as he would be doing without subrogation. The rule comes into play only if without it the operation of the subrogation clause would, by making the insured in effect pay back the policy benefits with money he has received for another loss caused by the injury that gave rise to the policy claim, leave him with an uncompensated injury. That would be the consequence of subrogating Jerome Foods to Mrs. Cutting's tort claim to the extent of the plan's medical benefits; the uncompensated nonmedical costs that she incurred as a result of the accident would be $90,000 greater if subrogation is permitted. One can see why many state courts have thought that the inclusion

of a boilerplate subrogation clause was not intended to have this effect — the effect, practically speaking, of curtailing coverage. To put this differently, rejection of "make whole" makes subrogation a lot like assignment. If insurance contracts required the insured to assign any tort claim he might have to the insurer, the price of the insurance would be lower but *effective* coverage would also be lower. The insured would recover only the policy limits, and not his full damages, even in a case in which a judgment had been secured against the tortfeasor, and collected, for those damage.

These arguments need not be thought decisive in favor of the make-whole rule. It is true that rejecting make whole would bring subrogation closer to assignment, but that would not necessarily be a bad thing. Assignment, by shifting the insured's tort right to the insurance company, reduces the price of insurance and thus enables the insured to obtain more coverage, in effect trading an uncertain bundle of tort rights for a larger certain right, which is just the sort of trade that people seek through insurance. (The counterargument is that the make-whole rule is most likely to apply in a case of catastrophic loss, such as the present, where full insurance is rare.) It can also be argued against the make-whole rule that it is administratively more complex, requiring the medical insurer to calculate the insured's total medical and nonmedical loss, and therefore that it makes insurance (or its equivalent in this case) more expensive to the insured — and makes it more expensive to him for the additional reason that he will have to pay for the additional coverage that the rule in effect provides. And no one's demand for insurance is unlimited. The counterargument on the administrative-complexity front is that subrogation (which the make-whole rule would eliminate in cases such as the present) involves an agency problem because of the insured's entitlement to any excess recovery that the insurer-subrogee obtains. The insurer, having no (or very little) interest in making money for the insured,

may fail to press hard for an excess recovery. See Keeton & Widiss, *supra*, §3.10(c)(2) at pp. 242-44. To which it can be replied that the make-whole rule simply shifts the disincentive to press hard from the insurer to the insured.

Fortunately we need not attempt to decide in this case whether the merits of the rule are sufficient on balance to warrant its use as a principle of interpretation of ERISA plans. Because, as the Cuttings concede, the make-whole rule is just a principle of interpretation, it can be overridden by clear language in the plan. Jerome Foods contends that the language is clear. The plan document does state rather flatly that the plan shall be subrogated to "all claims" by the covered individual against a third party to the extent of "any and all payments" made (or to be made) by the plan. But the language is no stronger than that in cases which have held that more was required to override the make-whole principle. And one of those cases *(Garrity)* is a Wisconsin case and Jerome Foods is a Wisconsin corporation (it both is incorporated in Wisconsin and has its principal place of business in that state), and this may be a clue to meaning, even though Wisconsin law does not govern the case. But at this point in the forensic badminton game the standard of judicial review becomes critical and decides the case in favor of Jerome Foods. For we cannot say that the company was *unreasonable* in interpreting this plan as disclaiming the make-whole principle. Had the Cuttings not refused to sign the reimbursement agreement, in effect the plan would have been advancing them their medical expenses against the possibility of a tort recovery sufficient to cover those expenses, and indeed such a recovery was obtained. This is as we have said a more limited form of insurance than is created by a make-whole provision, but Jerome Foods may not have been willing to provide — or the Cuttings to pay for — more generous coverage. We shall never know. We cannot say, however, that the administrator was unreasonable in

conducting that the plan had disclaimed any obligation to make the Cuttings whole.

Affirmed.

APPENDIX B — OPINION AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF WISCONSIN FILED DECEMBER 23, 1991

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

91-C-456-C

DIANE M. CUTTING and WARREN L. CUTTING,

Plaintiffs,

v.

JEROME FOODS, INC.

Defendant.

OPINION AND ORDER

In this civil action plaintiffs challenge defendant's interpretation of its employee benefits plan and seek declaratory relief under 29 U.S.C. § 1132. Defendant refuses to pay the medical bills of plaintiff Diane Cutting until plaintiffs execute a reimbursement agreement pursuant to the subrogation clause in the Jerome Foods, Inc. Health Care Plan, and has filed a counterclaim in which it seeks to enforce the subrogation clause and to require that plaintiffs execute the reimbursement agreement. Because this case involves the interpretation of an employee benefit plan regulated by the Employee Retirement Income Security Act (ERISA), jurisdiction exists pursuant to 29 U.S.C. § 1132 and 28 U.S.C. § 1331.

Defendant has moved for summary judgment on the ground that its interpretation of the Plan's subrogation clause is valid and enforceable under federal law. Plaintiff opposes the motion on two

grounds: that material issues of fact exist and that the common law of subrogation precludes defendant from seeking reimbursement before plaintiffs are fully reimbursed for Diane Cutting's injuries.

An order dated September 10, 1991 reflected the parties' agreement that until the court ruled on defendant's motion for summary judgment, 1) plaintiffs would not disburse further funds from the insurance proceeds; 2) plaintiffs would provide defendant with an accounting of the funds paid from the proceeds; and 3) defendant would pay medical bills incurred by plaintiffs after January 20, 1991, in an amount not to exceed the amount of funds remaining from the settlement proceeds. Following the entry of the September 10 order, plaintiffs filed a motion to allow them to pay medical bills from the funds they have received as insurance proceeds. Defendant filed a motion for reimbursement, refusing to disburse any money unless it receives reimbursement from the fund. In an order entered December 5, 1991, I declined to rule on these motions because a decision on defendant's motion for summary judgment would moot them. On December 13, defendant filed a request to enjoin plaintiffs from disbursing any funds received in a settlement against Ford Motor Company.

I conclude that there are no issues of material fact that preclude me from determining the validity and interpretation of the Plan's subrogation clause. I find that ERISA preempts the Wisconsin common law of subrogation and that it bars the courts from creating a federal common law fashioned after Wisconsin's common law of subrogation. Because the Plan grants defendant the discretion to interpret the Plan, I find that defendant's interpretation is not an abuse of discretion: the Plan's subrogation provision is set forth clearly in both the Plan and the Summary Plan Description. Therefore, defendant's motion for summary judgment will be granted, making it unnecessary to address the parties' additional motions.

Appendix B

For the purpose only of deciding defendant's motion for summary judgment, I find the following facts to be undisputed.

FACTS

Plaintiffs are citizens of Wisconsin. Defendant is incorporated in Wisconsin and has its principal place of business there. Defendant is a non-union employer under 29 U.S.C. § 1002(5) of ERISA and provides a self-funded group health plan to its employees. Defendant is the Plan administrator, Plan sponsor and named fiduciary, and the Plan is an employee welfare benefit plan within the meaning of 29 U.S.C. § 1002(1) of ERISA. The Plan states that "[a]ll decisions concerning the interpretation or application of this Plan shall be vested in the sole discretion of the Plan Administrator." A third party administrator, Travelers Plan Administrators of Minnesota, Inc., processes the claims. At all relevant times, plaintiff Warren Cutting has been an employee of defendant.

During an open enrollment period in 1988, defendant offered benefits coverage for families and individuals for the year 1989. According to the Summary Plan Description, employees must submit enrollment forms within 31 days of becoming eligible in order to enroll formally for health care coverage. Also, the Summary Plan Description provides that if an employee fails to submit an enrollment form, the employee receives individual coverage by default. Warren Cutting did not submit an enrollment form in 1988, and therefore received only individual coverage during 1989. In the 1989 enrollment period, Warren Cutting submitted an enrollment form designating family coverage and received family coverage starting January 1, 1990.

On December 25, 1989, plaintiff Diane Cutting suffered

serious injuries in an automobile accident involving an uninsured motorist. Plaintiffs received $126,000 from American Family Insurance in October or November 1990 under their automobile insurance policy covering uninsured motorists. Additionally, plaintiffs sued Ford Motor Company and settled their claim against the company for an undisclosed amount.[1] Diane Cutting's medical bills resulting from her injuries are expected to exceed the amounts she has received from American Family Insurance and Ford Motor Company.[2]

Plaintiffs submitted medical bills to Travelers for payment. Travelers requested that plaintiffs execute a reimbursement agreement pursuant to the Plan's subrogation provision, which reads as follows:

> By accepting any Plan payments of benefits arising out of illness, injury or medical condition, an individual (covered employee or dependent) agrees that the Plan shall be subrogated to all claims, demands, actions and rights or recovery of the individual against any third party or any insurer, including Workers' Compensation, to the extent of any and all payments made or to be made hereunder by the Plan. The Plan shall be entitled to commence an action and try or settle any legal actions it deems necessary in the name of and with the full cooperation of the individual or to intervene in any such actions already

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1. The terms of the settlement are sealed.

2. This fact is undisputed for the purpose of this motion only.

> commenced by an individual and will be reimbursed by the individual to the extent of any amounts paid or payable, past or future, from any third party by way of settlement or in satisfaction of judgment or agreement.
>
> The individual shall execute and deliver any and all instruments and papers requested by the Claim Administrator and shall do whatever is necessary to protect all of the Plan's rights. As a condition precedent to the payment of benefits hereunder, the individual shall, upon written request, execute a reimbursement agreement of the form to be provided by the Claim Administrator or its representative. The individual shall do nothing to prejudice the rights of the Plan to such reimbursement and subrogation and specifically agrees to notify and consult with the Claim Administrator before commencing any legal action concerning claims against any third party or its insurer relating to benefits paid hereunder.

The Summary Plan Description contains identical language.

Plaintiffs refused to sign the reimbursement agreement. On April 15, 1991, they initiated an action in state court to compel defendant to disburse its funds without subrogation or reimbursement rights until plaintiff Diane Cutting is fully reimbursed for her injuries. On May 15, 1991, defendant removed the case to this court pursuant to federal question jurisdiction. Initially, defendant maintained that Diane did not become eligible to receive benefits until January 20, 1990; it concedes now that her coverage became effective January 1, 1990.

Appendix B

OPINION

To succeed on a motion for summary judgment, the moving party must show that there is no genuine issue of material fact and that it is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Celotex Corp. v. Catrett,* 477 U.S. 317, 322 (1986). The opposing party may not rely solely on allegations and denials to defeat a motion for summary judgment, but must set forth specific facts showing that there is a genuine issue for trial. Fed. R. Civ. P. 56(e); *Billups v. Methodist Hosp. of Chicago,* 922 F.2d 1300, 1302 (7th Cir. 1991). If a party fails to make a showing sufficient to establish the existence of an essential element on which that party will bear the burden of proof at trial, summary judgment for the opposing party is proper. *Celotex,* 477 U.S. at 322. To determine this, courts must "resolve all doubts against the party seeking summary judgment." *Gracyalny v. Westinghouse Electric Corp.,* 723 F.2d 1311 (7th Cir. 1983).

Plaintiffs urge the court to allow a full development of the facts before ruling on an issue that will significantly affect the governance of employee benefit plans. According to plaintiffs, the remaining disputed questions of material fact include: Diane Cutting's current and future injuries and medical costs; the amount of plaintiff's recovery from American Family Insurance and Ford Motor Company; the injuries for which those recoveries represent compensation; and whether Diane has been reimbursed in full for her injuries.

However, no disputed questions of material fact exist on the initial question whether the Plan's subrogation clause can be enforced even though Diane Cutting has not been fully compensated. The extent of her injuries and amount of recoveries from third parties became relevant only if the Plan's subrogation

clause is declared invalid or if defendant's interpretation of the clause is an abuse of discretion.

Preemption

It is well established that state subrogation laws "relate[] to" employee benefit plans and are preempted by ERISA. 29 U.S.C. § 1144(a) (ERISA preempts state laws that "relate to any employee benefit plan); *FMC Corp. v. Holliday,* __ U.S. __, 111 S. Ct. 403, 407 (1990) ("Pennsylvania's anti-subrogation law 'relate[s] to' an employee benefit plan."). There is an exception to this rule for state laws regulating insurance, which are "saved" from preemption, 29 U.S.C. § 1144(b)(2)(A), and an exception to that exception: the "deemer" clause, § 1144(b)(2)(B), which forbids the states from "deeming" employee benefits plans to be insurance companies. Thus, self-funded employee benefit plans are exempt from state laws regulating insurance. *FMC Corp.*, 111 S. Ct. at 409; *Reilly v. Blue Cross & Blue Shield,* 846 F.2d 416, 425 (7th Cir. 1988), *cert. denied,* 488 U.S. 856 (1988). Although it may seem anomalous to allow state regulation of insured employee benefit plans but not of self-funded plans, that is the result dictated by ERISA. *Reilly,* 846 F.2d at 425 (citing *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 747 (1985)). Defendant's Plan escapes any Wisconsin subrogation rules because it is self-funded.

Federal Common Law

Plaintiff argues that this court should adopt as federal common law the rule that an administrator of an employee benefit plan may not seek subrogation until its beneficiary has been made whole. Under this rule, defendant cannot seek reimbursement for its payment of Diane Cutting's medical bills until she has been fully compensated for her injuries. In essence, plaintiffs are

arguing the unlawfulness of a subrogation clause that requires reimbursement before a beneficiary is made whole. Under this rule, defendant cannot seek reimbursement for its payment of Diane Cutting's medical bills until she has been fully compensated for her injuries. In essence, plaintiffs are arguing the unlawfulness of a subrogation clause that requires reimbursement before a beneficiary is made whole.

Plaintiffs offer several sound reasons for creating a "make-whole" federal common law rule of subrogation, which happens to be the doctrine of Wisconsin as well as of several other states. *See Garrity v. Rural Mutual Ins. Co.*, 77 Wis. 2d, 537, 541-544, 253 N.W. 2d 512, 514 (1977) (listing treatises and states that support the make-whole rule). First, since the purpose of subrogation is to prevent unjust enrichment, the general rule is that "subrogation does not arise until the debt has been fully paid." *Id.* at 541, 253 N.W. 2d at 514. Without this rule, a surety who is subrogated before its insured is fully compensated becomes a competitor with the insured for reimbursement. *Id.* at 542, 253 N.W. 2d at 514. This competition is obvious when a surety's obligation is limited. Along with other states, Wisconsin has decided that "where either the insurer or the insured must to some extent go unpaid, the loss should be borne by the insurer for that is a risk the insured has paid it to assume." *Id.* Plaintiffs argue that because Diane Cutting has not been made whole, the equities favor prohibiting subrogation until she is compensated in full. Otherwise, plaintiffs' payment of premiums to American Family Insurance will be solely for the benefit of defendant.

Because ERISA does not address the enforceability of subrogation provisions expressly, plaintiffs assert that this court may fashion federal common law to protect the interests of plan participants. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101,

110 (1988); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) (federal courts may create federal common law where ERISA is silent). Although the Court of Appeals for the Seventh Circuit has not ruled on the question directly, the rationale behind the Supreme Court's holding in *FMC Corp. v. Holliday*, 110 S. Ct. 403, appears to preclude the adoption of a make-whole subrogation rule as federal common law for self-funded employee benefit plans governed by ERISA. In *FMC Corp.*, the Supreme Court held that ERISA exempted self-funded plans from a Pennsylvania statute that prohibited insurers and employee benefit plans from exercising their subrogation rights. Relying on ERISA's goals of producing uniformity and eliminating state interference in self-funded employee benefit plans, the Court reasoned that "[a]pplication of differing state subrogation laws to plans would therefore frustrate plan administrators' continuing obligation to calculate uniform benefits nationwide." *FMC Corp.*, 111 S. Ct. at 409. Although the Court did not discuss whether a federal common law might be created to qualify a Plan's subrogation rights, its reasoning appears to preclude any federal common law that would alter the terms of a written employee benefit plan. Modeling a federal common law upon state subrogation law would hamper the "calculat[ion] of uniform benefits nationwide," since the states do not treat subrogation clauses identically, and a plan's subrogation provision would be enforceable in one federal court but not another.

Plaintiffs point to *Wahl v. Northern Telecom, Inc.*, 726 F. Supp. 235 (E.D. Wis. 1989) for support of their proposal for creation of federal common law. In *Wahl*, the court refused to enforce a subrogation clause against an employee benefit plan's beneficiary because the plan was not signed by the beneficiary and did not expressly require the beneficiary to repay. The court stated that it would not reach the question of "what, if any, federal limitations should exist on a self-insured employee benefits plan's rights to

subrogation against an insured . . . because the terms of the Plan in question do not provide the Plan with subrogation rights against [the beneficiary]." *Wahl*, 726 F. Supp. at 242. However, the court added in a footnote that if it "had to answer this question it would hold that federal common law should state that a self-insured plan can have no greater rights to subrogation against an insured than provided by state law." *Id.* n.4. The court reasoned that allowing self-insured plans to escape regulation of "non-core ERISA matters" would impede congress's goal of protecting beneficiaries and would lead to a lack of uniformity of regulation between insured and self-insured plans. *Id.*

Any force Wahl might have had has been undermined by *FMC Corp.*, 110 S. Ct. 403. It is true, as plaintiffs argue, that the consequence of the *FMC Corp.* holding is that insured plans will be "open to indirect regulation while [self-funded plans] are not." *Metropolitan Life*, 471 U.S. at 747. However, the Supreme Court has interpreted ERISA as creating just such a distinction. *Id.* Whether the distinction is a wise one is a question for Congress.

ERISA does not require employers to offer any benefits and does not dictate the terms of welfare benefit plans. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983); *Ryan v. Chromalloy American Corp.*, 877 F.2d 598, 603 (7th Cir. 1989) (employer may reserve right to terminate welfare benefits); *Young v. Standard Oil Co.*, 849 F.2d 1039, 1048 (7th Cir. 1988), *cert. denied*, 488 U.S. 981 (1988) (beneficiaries cannot "attack [] the substantive merits of the severance plan); *McGann v. H. & H. Music Co.*, 946 F.2d 401, 407 (5th Cir. 1991) ("Congress did not intend that ERISA circumscribe employers' control over the content of benefits plans"); *Hamilton v. Air Jamaica, Ltd.*, 945 F.2d 74, 78 (3rd Cir. 1991) (ERISA creates no substantive requirements for employee welfare benefit plans and employer can provide benefits on case by

case basis); *Musto v. American Gen. Corp.*, 861 F.2d 897, 911 (6th Cir. 1988), *cert. denied*, 490 U.S. 1020 (1989) (company does not act as fiduciary in deciding what terms of benefits plan will be).

Rather than regulating the substance of benefits plans, ERISA regulates the administration, disclosure and reporting of benefit plans to ensure that employees receive the benefits promised to them in writing. *McGann*, 946 F.2d 401; *Hamilton*, 945 F.2d at 78. This approach retains the employer's flexibility in designing plans and also protects the beneficiaries' interest by holding employers to the written terms of the Plan. Regardless of state public policy, "ERISA preempts state law and lets a health and welfare plan draft its own rules." *Sisters of the Third Order of St. Francis v. Swedish American Group Health Benefit Trust*, 901 F.2d 1369 (7th Cir. 1990).

Because ERISA's primary method of protecting beneficiaries is to ensure that they receive promised benefits, there is no need to fashion an equitable remedy under ERISA "where there is no violation of ERISA under the written terms of the plan." *Cummings By Techmeier v. Briggs & Stratton Retirement Plan*, 797 F.2d 383, 385 (7th Cir. 1986), *cert. denied*, 479 U.S. 1008 (1986) (refusing to impose constructive trust where there were no violations of the benefit plan's written terms of ERISA fiduciary duties). Creating a federal common law "make-whole" rule of subrogation would substantially change the design of defendant's Plan. To do so would be tantamount to dictating the substance of defendant's Plan, and would have the effect of allowing state law to govern in an area in which state law is preempted.

Other courts have reached a similar conclusion. *See Provident Life & Accident Ins. Co. v. Linthicum*, 930 F.2d 14 (8th Cir. 1991) (ERISA allows subrogation clause to be enforced regardless whether beneficiary made whole); *Dugan v. Nickla*, 763 F. Supp.

981, 984 (N.D. Ill. 1991) (ERISA plan subrogation clause to recover medical payments is enforceable against all money recovered by beneficiary, whether or not for medical expenses); *General Business Forms, Inc. v. Thornburg,* 1989 U.S. Dist. LEXIS 10192, at *16 (N.D. Ill. 1989) (finding that ERISA preempts Illinois anti-subrogation law but that terms of policy revived it); *Pugh v. Wilson,* 693 F. Supp. 1096, 1102 (S.D. Fla. 1988) (ERISA preempts Florida collateral source statute insofar as it would prohibit the enforcement of employee benefit plan's subrogation clause).

Plaintiffs argue that allowing defendant to enforce the subrogation provision will be equivalent to saying that defendant is above the law. Plaintiffs liken the Plan to a contract of adhesion, arguing that defendant did not bargain with its employees regarding the Plan's terms and that plaintiffs were faced with the choice of either accepting the Plan "as is" or going without any health insurance. However, defendant has no fiduciary duty to its employees when it determines the terms of its welfare benefits plan, *Young v. Standard Oil Co.,* 849 F.2d at 1045. Plaintiffs could have sought health coverage elsewhere. Furthermore, as defendant points out, ERISA imposes a fiduciary duty on plan administrators to follow the plan's terms. An administrator's denial of benefits is subject to *de novo* review by federal courts, unless the plan gives the administrator discretion to determine benefits and interpret the plan, in which case its decision is subject to a more deferential review. *See* 29 U.S.C. §§ 1101 *et seq.* (establishing responsibilities of fiduciaries). Thus, there are some restraints on plan administrators.

Standard of Review

Once it is determined that a self-funded employee benefit

plan's unqualified subrogation clause is not unlawful in and of itself, the next step in the analysis is to determine whether defendant's interpretation of *this* Plan's subrogation clause can be upheld.

Defendant argues that the standard of review for its interpretation of the Plan is deferential, rather than *de novo,* because the Plan grants the administrator sole discretion to interpret the terms of the plan. *Firestone,* 489 U.S. at 111 ("deferential standard of review appropriate when a trustee exercises discretionary powers"); *Fuller v. CBT Corp.,* 905 F.2d 1055, 1058 (7th Cir. 1990) (abuse of discretion standard appropriate where trustee had discretion to interpret plan).

Plaintiffs offer several arguments against a deferential standard of review. Citing *Dugan v. Nickla,* 763 F. Supp. 981, plaintiffs assert that deferential review is appropriate only for denial of benefits, not for declaratory judgments. In *Dugan,* the court stated in a footnote that the *Firestone* deferential standard was restricted to denial of benefits, but it added that the employer's interpretation of its plan was not arbitrary and capricious, which indicates a deferential standard. 763 F. Supp at 984 n.6. As defendant points out, in *Dugan* the plaintiffs sought to enforce a surrogation provision against a beneficiary that had recovered a damage award against a doctor in a malpractice action. The court upheld the plaintiff's interpretation of the subrogation clause that allowed reimbursement not only from damages awarded to the beneficiary for medical expenses, but also for damages awarded for disfigurement, with an amount subtracted for attorneys' fees. 763 F. Supp. at 982. *Dugan* supports defendant's position that it can seek reimbursement from all the funds plaintiff receives from third parties.

Appendix B

Plaintiffs argue that a less deferential standard of review is appropriate because defendant has a conflict as Plan administrator between the beneficiaries' interest in receiving benefits and the Plan's interest in preserving assets. Because of this conflict, plaintiff asserts, defendant is biased toward denying benefits, and thus its decisions should be reviewed with more scrutiny. In *Firestone*, 489 U.S. at 115, the Supreme Court stated that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion." It did not hold that a different standard applies when a conflict exists. Rather, the conflict must be taken into account during a court's deferential review. Additionally, the fact that an employer administers its own employee benefits plan does not automatically create a conflict of interest that would warrant a *de novo* review if the Plan grants that employer total discretion to interpret the Plan. *See* 29 U.S.C. § 1102(a)(1) and (2); 29 U.S.C. § 1102(c)(1) (allowing person to hold more than one fiduciary position).

In addition to asserting a conflict of interest, plaintiffs charge that defendant has acted in bad faith in refusing to pay any money before securing a reimbursement agreement and in requiring reimbursement from all sources. However, defendant's refusal to pay is based upon its reading of the Plan's subrogation clause: it seeks to enforce the clause as it has interpreted it. Seeking to enforce a contractual right cannot rise to the level of bad faith. Further, there is no merit to plaintiffs' assertion of bad faith based on defendant's change from its initial position that Diane Cutting was not eligible for benefits until January 20, 1990. That defendant has changed its position upon a closer review of the Plan is not bad faith; defendant has acknowledged its error, and has admitted its liability for benefits beginning January 1, 1990.

Finally, plaintiffs assert that a less deferential review is appropriate because defendant acted in bad faith by changing its benefits plan and requiring employees to "opt-in" for family benefits, even if those employees had carried family coverage under the previous benefits design. However, the courts are not empowered to design benefit plans; they can only ensure that employers act in accordance with the plans they implement. In any event, there are legitimate reasons for automatically assigning individual coverage for employees who do not return formal enrollment information. It is reasonable to assume that an employee will want coverage for himself, but it may not be reasonable to assume that an employee also wants coverage for his family. His family may be covered by separate insurance — perhaps through his spouse's benefit plan. Defendant could have designed a plan in which an employee who did not make a formal choice of coverage would not receive *any* coverage. Instead, defendant chose single coverage as a default, a choice well within its power to make.

Furthermore, that plaintiffs were unaware of the Plan's enrollment and subrogation provisions does not suspend the Plan's force. Although Warren Cutting stated in his affidavit that no one explained the subrogation provision to him, he does not allege that he was not given a copy of the Summary Plan Description or that he did not have access to the written Plan. Plaintiffs deny that Warren Cutting was informed of the requirement that he "opt-in" for family coverage, but they do not contest defendant's proposed finding of fact that this information was disseminated to employees. Plaintiffs do not explain why Warren Cutting was not aware of the Plan's requirements. If they are asserting that he did not read the Plan Summary or other materials, this does not create a dispute as to whether defendant breached its fiduciary duty to disseminate an understandable, written Summary Plan Description. 29 U.S.C. § 1102(a)(1) (plan must be "established and

maintained pursuant to written agreement); 29 U.S.C. § 1022(a)(1) (Summary Plan Description must be accurate and understandable). Ignorance of a contract's terms is not a defense to its enforcement. Defendant does not have a duty to give individualized advice or information to each employee regarding its benefits plan. *Cummings By Techmeier,* 797 F.2d at 387 (" 'fiduciaries are not expected to provide individualized attention to participants' " (quoting *Lee v. Union Elec. Co.,* 606 F. Supp. 316, 321 (E.D. Mo. 1985)). Additionally, the Plan need not describe every possible consequence that might flow from the subrogation clause. *Lorenzo v. Employee Retirement Plan of Sperry & Hutchinson Co., Inc.,* 896 F.2d 228 (7th Cir. 1990).

For the reasons discussed above, I am not persuaded by plaintiffs' arguments that a less deferential review is required. The Plan makes it explicit that sole discretion to interpret the Plan is placed in the defendant as the Plan administrator. Therefore, I will review defendant's interpretation deferentially, and will affirm it unless the interpretation is an abuse of discretion. *Fuller,* 905 F.2d at 1058 (abuse of discretion means "not just clearly incorrect but downright unreasonable").

Interpretation of the Plan's Subrogation Provision

The Plan's subrogation provision provides for subrogation for "*all* rights or recovery . . . against *any* third party or *any* insurer . . . to the extent of *any and all* payments made or to be made by the Plan." (Emphasis added). Plaintiffs assert that this provision does not provide expressly for subrogation in the event that plaintiffs are not made whole, distinguishing this Plan's subrogation provision from the one in *Dugan,* 763 F. Supp. at 984, which provided

> Upon any recovery . . . from any person . . . insurance company, whether by suit, judgment,

> settlement, compromise, or otherwise, the Trustees . . . shall be entitled to immediate reimbursement to the extent of benefits paid . . . The Trustees shall be first reimbursed fully by such Employee, . . . to the extent of benefits paid . . . from the monies paid by any person . . . and the balance of monies, if any, then remaining from such recovery shall be retained by the Employee . . .

Plaintiffs are not persuasive in their attempts to distinguish defendant's Plan's clause from the clause in *Dugan*. The import of both clauses is that after paying benefits, the Plan has first claim to any money recovered from third parties. Neither clause makes the right to subrogation subject to the condition that beneficiaries reimbursed in full for their injuries. The Plan's requirement that plaintiffs sign a reimbursement agreement as a "condition precedent" to receiving benefits is equally clear. Under a deferential review standard, I cannot find that defendant's interpretation of its Plan is an abuse of discretion.

Plaintiffs argue that the subrogation clause is unenforceable against the money recovered from plaintiff's uninsured motorist insurance policy because plaintiff's insurance carrier is not a third party within the meaning of the Plan's subrogation provision. However, the Plan provides expressly that it is subrogated to claims against any insurer. Additionally, the plain meaning of "third party" includes any entity that is not a party to an agreement, that is, in this case, any party other than the defendant and plaintiff. In any event, defendant's interpretation of this provision is not an abuse of discretion, and therefore will be affirmed.

I conclude that defendant may enforce its subrogation rights

against plaintiffs and require them to execute a reimbursement agreement before receiving any payment from the Plan. There remains the question whether defendant can recover the money received by Plaintiffs that represent attorneys' fees. Although neither party has addressed this issue, I conclude that the Plan's reimbursement clause does not include amounts attributable to attorneys' fees incurred by plaintiffs in pursuit of their claim against Ford. *See Dugan,* 763 F. Supp. at 984-85. Holding otherwise would allow defendant not only to reap the rewards of plaintiffs' legal action against Ford, but would allow it also to receive attorneys' fees although it did not incur any legal costs in pursuing the claim against Ford. As the court stated in *Dugan,* 763 F. Supp. at 984, if plaintiffs had not "engaged an attorney and pursued [their] claim, the Fund would not have recovered any of the benefits paid." Therefore, the only issue remaining in this case is the extent to which plaintiffs' recovery against Ford represents attorneys' fees.

This decision to uphold defendant's interpretation of the Plan's subrogation clause makes it unnecessary to address defendant's arguments that subrogation should be allowed to prevent plaintiffs from being unjustly enriched or that plaintiffs are not entitled to a jury trial.

ORDER

IT IS ORDERED THAT defendant's motion for summary judgment is granted. Plaintiffs are directed to execute the reimbursement agreement. Defendant may seek reimbursement from the insurance proceeds and from the settlement with Ford, except for that portion of the settlement funds that represents attorney fees.

Appendix B

Entered this 23rd day of December, 1991,

BY THE COURT:

s/Barbara B. Crabb
BARBARA B. CRABB
District Judge

(2)

Supreme Court, U.S.
FILED
SEP 17 1993
OFFICE OF THE CLERK

No. 93-268

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1993

DIANE M. CUTTING AND WARREN L. CUTTING,
Petitioners,

v.

JEROME FOODS, INC.,
Respondent,

ON PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION

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16 pp

COUNTERSTATEMENT OF THE QUESTION PRESENTED

Should the Court reconsider and overrule *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), and adopt a new standard of judicial review of a benefit denial decision by an administrator of a self-funded plan who has been given discretion to interpret the plan and allegedly has a conflict of interest?

RULE 29.1 STATEMENT

Jerome Foods, Inc. has two subsidiaries: Jerome Food FSC, Inc., and Jerome Trucking, Inc. It has no parent company.

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No. 93-268

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1993

DIANE M. CUTTING AND WARREN L. CUTTING,

Petitioners

v.

JEROME FOODS, INC.,

Respondent

On Petition For A Writ Of Certiorari To
The United States Court of Appeals For The Seventh Circuit

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

COUNTERSTATEMENT OF THE CASE

This case involves whether Respondent Jerome Foods Inc. (Respondent) reasonably interpreted its Health Care Plan (Plan) to require Petitioners to sign an agreement to reimburse the Plan from amounts they received from other sources as a condition to receiving Plan benefits.

Petitioner Diane Cutting was injured in an automobile accident on December 25, 1989. Petitioners received $126,000 in settlement from their uninsured motorist carrier and $500,000 from Ford Motor Company on a products liability claim related to the accident. For purposes of the motions below, it was conceded that the settlements did not fully compensate Mrs. Cutting.

Petitioner Warren Cutting is an employee of Respondent, a Wisconsin corporation. Effective January 1, 1990, Mr. Cutting elected to cover Petitioner Diane Cutting, his spouse, under the Plan. The Plan is an employee welfare benefit plan which is self-funded and administered by Respondent. Under the terms of the Plan, "all decisions concerning the interpretation or application" of the Plan are vested in the sole discretion of Respondent as Plan Administrator.

Petitioners submitted medical bills relating to the accident to the Plan. In accordance with the terms of the Plan, prior to paying any medical claims, Respondent required Petitioners to sign an agreement to reimburse the Plan for any amounts that Petitioners received from other sources. The relevant Plan provision provides:

> By accepting any Plan payments of benefits arising out of illness, injury or medical condition, an individual (covered employee or dependent) agrees that the Plan shall be subrogated to all claims, demands, actions and rights of recovery of the individual against any third party or any insurer, including Workers' Compensation, to the extent of any and all payments made or to be made hereunder by the Plan. The Plan shall be entitled to commence an action and try or settle any legal actions it deems necessary in the name of and with the full cooperation of the individual or to intervene in such actions already commenced by an individual and will be reimbursed by the individual to the extent of any amounts paid or payable, past or future, from any third party by way of settlement or in satisfaction of judgment or agreement.
>
> The individual shall execute and deliver any and all instruments and papers requested by the Claim Administrator and shall do whatever is necessary to protect all of the Plan's rights. As a condition precedent to the payments of benefits hereunder, the individual shall, upon written request, execute a reimbursement agreement of the form to be provided by the Claim Administrator or its representative. The individual shall do nothing to prejudice the rights of the Plan to such reimbursement and subrogation and specifically agrees to notify and consult with the Claim Administrator before commencing any legal action concerning claims against any third party or its insurer relating to benefits paid hereunder.

Petitioners refused to sign the agreement and, instead, commenced suit in state court for benefits under the Plan. Respondent removed the case to the United States District Court for the Western District of Wisconsin which granted Respondent's Motion for Summary Judgment. 820 F.Supp. 1146 (W.D.Wisc. 1991). The district court found that the Wisconsin common law of subrogation was preempted by the Employee Income Security Act of 1974 (ERISA), as amended, 29 U.S.C. §1001, *et*

seq. and that ERISA barred the court from creating a federal common law fashioned after Wisconsin's common law. It found further that the Plan granted Respondent the discretion to interpret the Plan and that Respondent's interpretation requiring the execution of the agreement as a condition to benefit payments was not an abuse of discretion. Furthermore, the district court found that the fact that Respondent administered its own Plan did not automatically create a conflict of interest, and that Respondent had not been guilty of bad faith by refusing to pay the claim.

The Court of Appeals affirmed. 993 F.2d 1293 (7th Cir. 1992). On appeal, Petitioners urged adoption as federal common law, a "make whole" subrogation rule which would require that they be fully compensated for all injuries prior to the exercise of any right of subrogation by the Plan. The Court of Appeals concluded that "make whole" subrogation was, at best, an interpretative rule to fill gaps in a plan otherwise silent on subrogation and could be overcome by clear plan language. The Court found it unnecessary to adopt a "make whole" subrogation rule, holding that Respondent's interpretation of the Plan to require the execution of the agreement was reasonable in light of the discretion given to the Administrator to interpret the Plan.

REASONS FOR DENYING THE WRIT

The petition should be denied because the question posed was unanimously resolved by a recent decision of the Court. The Courts of Appeal apply the standard set by the Court and there is no conflict among the circuits on this issue. The case presented applies the well settled standard to the review of the interpretation of a particular document.

I. The Question Presented Was Answered in *Firestone Tire & Rubber Co. v. Bruch*

The question presented in the petition, the standard of review under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, 29 U.S.C. §1001 *et seq.*, of a benefits decision by a plan administrator, was answered by the Court in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). Petitioners argue that where the plan document of a self-funded employee welfare benefit plan gives the administrator discretion to construe plan terms, that decision should be

reviewed by the court under a *de novo* standard if the fiduciary is subject to a potential conflict of interest. *Firestone* expressly rejects this argument.

In *Firestone*, the Court addressed the appropriate standard of judicial review of benefit determinations by fiduciaries and plan administrators under ERISA. In that case, the employer had established benefit plans for which it served as administrator, fiduciary and sole source of funding. 489 U.S. at 105. After Firestone sold five plants as going concerns, six former employees who had been hired by the purchaser, sought severance payments from Firestone. Firestone rejected the severance claims based on its interpretation that the sale of the plants did not constitute a "reduction of the workforce" within the meaning of the severance plan.

The district court granted summary judgment for Firestone holding that it did not act in an arbitrary or capricious manner in denying the severance claims. 640 F. Supp. 519 (E.D.Pa. 1986). The Court of Appeals, noting that Firestone was the plan administrator and that benefits from the unfunded plan came directly from its general assets, declined to use the arbitrary and capricious review standard. Instead, it held that where the employer itself is the fiduciary and administrator of an unfunded benefit plan, deference is unwarranted and its decision to deny benefits should be subject to *de novo* judicial review. (828 F.2d at 137-145).

This Court unanimously rejected this analysis. Applying principles of trust law, the Court distinguished between situations where the plan document vests discretion on the fiduciary or administrator and those which do not. If a fiduciary is given power to construe disputed or doubtful terms, ". . . the trustee's interpretation will not be disturbed if reasonable." (489 U.S. at 111). However, if the document is silent with respect to discretion, the judicial standard of review is *de novo*.

The Court specifically addressed the Court of Appeals' concerns about conflicts of interests as follows (489 U.S. at 115):

> . . . [A] denial of benefits . . . is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan. Because we do not rest our decision on the concern for impartiality that guided the Court of Appeals, see 828 F. 2d, at 143-146, we need not distinguish

> between types of plans or focus on the motivations of plan administrators and fiduciaries. Thus . . . the *de novo* standard of review applies whether the plan at issue is funded or unfunded and regardless of whether the administrator or fiduciary is operating under a under a possible or actual conflict of interest. *Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that factor must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.' Restatement (Second) of Trusts §187, Comment d (1959).* (emphasis supplied).

Thus, the appropriate standard of review in cases such as this was unanimously announced by the Court just four years ago.

The *Firestone* standard is clear. Where, as in this case, the plan document gives the plan administrator discretion to interpret the plan, any conflict of interest shall be considered as a factor in determining whether there has been an abuse of discretion. Petitioners seek to have the Court reconsider and reverse *Firestone*. The petition urges, in effect, that the Court now accept the holding of the Court of Appeals in *Firestone* that all potential or actual conflicts of interest be reviewed *de novo* — a holding the Court specifically rejected in that case.

The petition offers no sufficient reason why the Court should reconsider this question and overrule its recent decision in *Firestone*. The petition should be denied.

II. There Is No Conflict Among The Courts of Appeal to Be Resolved

The petition suggests that certiorari be granted because of alleged conflicts among the Seventh, Tenth and Eleventh Circuits concerning the appropriate standard of review in ERISA benefit denial cases. An examination of the cases cited by Petitioners shows there is no conflict among the circuits requiring resolution by the Court.

Petitioners refer to immaterial verbal differences in the formulation, not the application, of the standard. The petition seeks to exalt distinctions without differences. Justice Ginsburg, then writing for the Court of Appeals for the District of Columbia Circuit in *Block v. Pitney Bowes, Inc.*, 952 F.2d 1450, 1454 (D.C. Cir. 1992), explained the fallacy of petitioners' argument concerning different statements of the review standard:

> Some post-*Firestone* decisions, dealing with plans that "give[ ] the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan, " see id. at 115, 109 S.Ct. at 956, speak dominantly of judicial control for "abuse of discretion." See, e.g., *Jones v. Laborers Health & Welfare Trust Fund*, 906 F.2d 480, 481 (9th Cir. 1990); *DeWitt v. A State Farm Ins. Cos. Ret. Plan*, 905 F.2d 798, 800 (4th Cir. 1990). Other decisions invoke the "arbitrary and capricious" formulation. See, e.g., *Exbom*, 900 F.2d at 1141-42; *Lakey v. Remington Arms Co.*, 874 F.2d 541, 544 (8th Cir. 1989). In view of the Supreme Court's alternating references, these lower court formulations seem to us unremarkable.
>
> The distinction, if any, between "arbitrary and capricious review" and review for "abuse of discretion" is subtle. Cf. *Ass'n of Data Processing Service Organizations, Inc. v. Board of Governors of Federal Reserve System*, 745 F.2d 677, 684 (D.C.Cir. 1984) (Scalia, J.) (distinction between substantial evidence test and arbitrary or capricious test is " 'largely semantic' ") (citations omitted). In the matter at hand we are satisfied, there is no need to adopt one phrase and avoid the other. The reasonableness of the Plan Committee's decision is our polestar. . . .

There is no conflict between the standard of review applied in the Seventh, Tenth and Eleventh Circuits. Each Circuit accepts and properly applies the standard announced by the Court in *Firestone*.

In cases where the plan document gives the plan administrator discretion to interpret the plan, the Seventh Circuit has upheld the decision if reasonable. *Lister v. Stark*, 942 F.2d 1183 (7th Cir. 1991); *Saracco v. Local Union 786 Pension Fund*, 942 F.2d 1213 (7th Cir. 1991).

The Eleventh Circuit has equated the abuse of discretion standard with the "arbitrary and capricious" standard in its post-*Firestone* cases. *Brown v. Blue Cross and Blue Shield of Alabama, Inc.*, 898 F.2d 1556, n.1 (11th Cir. 1990) *cert. denied*, 498 U.S. 1040 (1991). The Seventh Circuit has described this difference in terminology not as one of substance, but as splitting semantic hairs (*Lister v. Stark, supra*, 942 F.2d at 1188), and has cited *Brown* with approval. *Fuller v. CBT Corp.*, 905 F.2d 1055, 1058 (7th Cir. 1990). The Seventh Circuit has itself also used the "arbitrary and capricious" formulation. *Egert v. Connecticut General Life Insurance Co.*, 900 F.2d 1032 (7th Cir. 1990); *Saracco, supra*, 942

F.2d at 1214. Regardless of the label, the Eleventh Circuit will uphold benefit denial decisions if the interpretation ". . . was made rationally and in good faith — not whether it was right." *Guy v. Southeastern Iron Workers' Welfare Fund*, 877 F.2d 37, 39 (11th Cir. 1989). This standard is indistinguishable from the standard of "reasonableness" used by the Seventh Circuit.

The Tenth Circuit also utilizes the "arbitrary and capricious" standard in reviewing decisions of an administrator vested with discretion to construe a plan. However, the Tenth Circuit also focuses on the reasonableness of the decision. In *Woolsey v. Marion Laboratories, Inc.*, 934 F.2d 1452, 1457 (10th Cir. 1991), the Court of Appeals framed the applicable standard in words virtually identical to those of the other circuit courts: ". . . we must now determine if the Administrators' reasons for denying [the] request were so insufficient or unreasonable as to be arbitrary and capricious." *See also Millensifer v. Retirement Plan for Salaried Employees of Cotter Corporation*, 968 F.2d 1005, 1009 (10th Cir. 1992) (where two interpretations are rational, ". . . we must defer to the retirement committee's reasonable construction absent administrative bias").

The petition argues that in this case the Seventh Circuit ignored possible conflicts of interest. That assertion is belied by the Court of Appeals' explicit discussion of conflicts and of this Court's decision in *Firestone* in this case (4a-5a), as well its concern about the issue as early as *Van Boxel v. The Journal Company Employees' Pension Trust*, 836 F.2d 1048 (7th Cir. 1987), which is cited by the Court in *Firestone*. *See also Rizzo v. Caterpillar, Inc.*, 914 F.2d 1003, fn. 2 (1990).

Finally, Petitioners rely upon a law review article, George Lee Flint, Jr., *ERISA: The Arbitrary and Capricious Rule Under Siege*, 39 Cath. U. L. Rev. 133 (1989) as a primary reason for the Court to grant certiorari. Flint argues that the proper standard of review in conflict of interest cases should be the *de novo* review standard. The author simply disagrees with the Court's resolution of the issue in *Firestone*, and appears to favor the discredited approach adopted by the Court of Appeals in that case. A single commentator's disagreement with the Court hardly provides a sufficient reason for granting the petition. The position advanced is simply a rehash of an argument the Court has considered and rejected.

There is no Circuit conflict requiring review by the Court. Each Circuit follows *Firestone*, and reviews benefit denials to see whether the decision was reasonable when deference to an administrator is required

by plan language. That is exactly what the Court of Appeals did in this case. Review of that decision is unwarranted.

III. The Question Presented Involves a Narrow Interpretation of a Provision of a Single Plan and Would Be of Little Precedential Effect

The narrow question presented is not sufficiently important to warrant the Court's attention. The case simply involves whether this Plan administrator's interpretation of the provisions of this particular Plan was reasonable in requiring, as a condition of payment, reimbursement from settlement proceeds before a claimant was made whole. Not only is the issue a narrow one, but it was decided correctly below.

ERISA does not mandate that employers provide any particular benefits. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 91 (1983). The Act ". . . does not regulate the substantive content of welfare-benefit plans." *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 732 (1985).

> Instead, Congress intended employers to be free to create, modify, or terminate the terms and conditions of employee welfare benefit plans as inflation, changes in medical practice and technology, and the costs of treatment dictate.

Owens v. Storehouse, Inc., 984 F.2d 394, 398 (11th Cir. 1993); *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988). Instead, ERISA regulates the administration, disclosure and reporting of benefit plans and protects beneficiaries by making sure they receive the benefits that have been promised to them in writing. *McGann v. H&H Music Co.*, 946 F.2d 401, 407 (5th Cir. 1991), *cert. denied*, 113 S.Ct. 482 (1992); *Hamilton v. Air Jamaica, Ltd.*, 945 F.2d 74, 78 (3d Cir. 1991), *cert. denied*, 112 S.Ct. 1479 (1992).

Recognizing that the welfare benefit plan at issue is self-funded and that under *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), all state subrogation laws are preempted by ERISA, petitioners have urged that the "make whole" rule of subrogation be applied to self-funded plans as federal common law. Under this regime, all self-funded plans would be required to refrain from reimbursement from third-party proceeds unless and until the claimant was made whole for any injuries sustained.

The district court rejected this position. It held that the reasoning of *FMC Corp.* ". . . appears to preclude any federal common law that would alter the terms of a written employee benefit plan." (21a). The court expressly rejected claims that the administrator acted in bad faith in his interpretation of the Plan. (26a).

Although adopting a different approach, the Court of Appeals also viewed the issue as ultimately one of how this particular welfare Plan was designed and interpreted. Writing for a unanimous panel, Judge Posner noted that the rule of subrogation urged by petitioners is not a substantive requirement, but a rule of interpretation. He states that "[i]t is difficult to say whether the 'make whole' interpretative principle is predominant, let alone universal." (7a). "The right exists only when the parties are silent. It is a gap filler." (7a). The court then discussed whether a "make whole" subrogation rule was advisable. (7a-11a). Judge Posner concluded (11a):

> Fortunately we need not attempt to decide in this case whether the merits of the rule are sufficient on balance to warrant its use as a principle of interpretation of ERISA plans. Because, as the Cuttings concede, the make-whole rule is just a principle of interpretation, it can be overridden by clear language in the plan.

The Court then addressed the narrow issue of whether this Plan, as drafted, required petitioners to execute a subrogation agreement prior to receiving benefits. The Plan gives the administrator the discretion to interpret its provisions. (3a). The court noted (11a):

> The plan document does state rather flatly that the plan shall be subrogated to 'all claims' by the covered individual against a third party to the extent of 'any and all payments' made (or to be made) by the plan.

Applying the *Firestone* standard, Judge Posner concluded that the company's interpretation of the Plan was not unreasonable in concluding that the Plan had disclaimed any obligation to make petitioners whole.

ERISA permits an employer to design its benefit plans free of interference and requires that such plans be adhered to as written. The Court established the standard of judicial review of benefit denial cases in *Firestone*. This case presents nothing more than a routine application of that well-settled standard to a particular set of facts under the provi-

sions of this Plan. There is no adequate reason for the Court to review this case. Even if petitioners would have been entitled to "make whole" subrogation under pre-ERISA law, as the Court noted last session, ERISA is ". . . an enormously complex and detailed statute that resolved innumerable disputes between powerful competing interests — not all in favor of potential plaintiffs." *Mertens v. Hewitt Associates*, 113 S.Ct. 2063, 2071 (1993). Under these circumstances, this case is not sufficiently important to warrant review.

CONCLUSION

For these reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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